



**Tommy** is a typical 9 year-old boy playing soccer at the local recreation center. While playing one afternoon, Tommy runs after a loose ball into the street and is hit by a car...

A crowd of friends gathers around Tommy while waiting for the ambulance to come. Tommy appears awake, but he is dazed and not talking to anyone.

Tommy is rushed by ambulance to the emergency department. He is awake, disoriented, and crying to see his parents, who have not yet arrived. He tells a nurse that he is in pain and very scared. The nurse does her best to reassure Tommy and she spends a lot of time talking to him.

Tommy's parents arrive and he seems calmer. Tommy has surgery for internal injuries and a leg fracture and is admitted to the hospital for follow-up care.

Tommy's parents are very anxious and upset as they wait for news of his condition. They are dealing with a lot of forms to fill out, questions from strangers, and feelings of uncertainty. They also have to arrange for a relative take care of their other two children at home. People from the recreation center are calling and asking about Tommy. A social worker takes the time to talk with Tommy's parents.

### Intervention Point #1: PREHOSPITAL AND FIRST RESPONSE

**D** Providers treating Tommy should be aware that:

1. The sights and sounds of an ambulance can be very frightening for children, who may overestimate life threat or seriousness of their condition.
2. A child's perception of life threat can be unrelated to actual injury severity; therefore, provider's medical impressions can be different from what the child is thinking or feeling.
3. Like many other children who may be in his situation, Tommy is in pain, separated from his parents, and feels alone and scared. All of these factors can contribute to current traumatic stress reactions in children and potential persistent posttraumatic stress.

### Intervention Point #2: EMERGENCY AND TRAUMA

**D E** Providers treating Tommy should be aware that:

1. Tommy is in pain and initially separated from his parents, which are potential risk factors for persistent posttraumatic stress.
2. The sights and sounds of the emergency department and hospital can be very frightening for children, who may overestimate life threat and the seriousness of their condition.
3. A child's perception or impressions of life threat can be unrelated to actual injury severity; therefore providers' medical impressions can be different from what the child is thinking and feeling. All of these factors can contribute to current traumatic stress reactions in children and potential persistent posttraumatic stress.

See page 12 for recommended assessments and interventions for Tommy and his family.

Tommy's internal injuries are quite extensive. He is in critical condition for the first two days. Tommy's parents are very anxious and upset during this time. They are having a difficult time sorting through all of the medical information. A lot of friends and relatives are calling and they don't know what to tell them. Tommy's younger brother comes to the hospital and asks "Is Tommy going to die?"

Finally, Tommy begins to stabilize. He is talking and aware of his surroundings but still very confused about what happened. He cries a lot and is afraid to be left alone. Tommy's injuries are extensive enough to keep him in the hospital. He will need rehabilitation and physical therapy to help him walk correctly again.



Being in rehabilitation and having physical therapy is very difficult for Tommy at first. He cries and gets angry when he has a difficult time walking, and has nightmares about being chased by a car. He reports having flashbacks of being in the ambulance, alone, and scared. Tommy tells his parents "I never want to play soccer again!"



### Intervention Point #3: INPATIENT CARE

**E F** Providers treating Tommy should be aware that:

1. Like other families in their situation, Tommy's parents feel anxious and upset due to unexpected hospitalization and uncertain prognosis, which are associated with increased traumatic stress responses.
2. Traumatic stress responses can be unrelated to injury severity. Parents who are afraid that their child might die, or children who are afraid that they might die at some point during the trauma can have more significant traumatic stress responses.
3. During initial hospitalization, children and parents often don't know what to expect. What may seem "routine" to providers, staff, and experienced families can seem unfamiliar, awkward, and sometimes frightening to newly admitted children and families. It is helpful to spend extra time with patients and families initially, and to explain routines and procedures to them in advance.

### Intervention Point #4: REHABILITATION

**D E F** Providers treating Tommy should be aware that:

1. Children and families can become more anxious or upset as a result of changes in the medical environment, such as the transition to rehabilitation. They sometimes experience these transitions as losses, especially when it involves changes in providers or the treatment team.
2. Children can experience significant pain, emotional loss, anger or frustration when challenged to do something that once came naturally, but is now more difficult because of the injury. In addition, traumatic reminders of the event can be triggered during rehabilitation.
3. Children with significant physical injuries can often feel different from their peers. They might withdraw from friends and family or feel depressed as a result.

See page 12 for recommended assessments and interventions for Tommy and his family.



Tommy has made a lot of progress physically and has made some new friends at the rehabilitation center. Soon, it will be time for him to return home. He is anxious about leaving the hospital and says he never wants to go back to the recreation center again.

Tommy has returned home and things seem to go well the first few days. However, when it's time for Tommy to get in the car and return for outpatient physical therapy, he becomes irritable and refuses to leave the house. With Dad's encouragement, he finally gets into the car, but he is very quiet and withdrawn, even when he sees familiar staff there.



Over the next few days, Tommy complains of feeling sick, and not wanting to go anywhere. Mom arranges to have a few of Tommy's friends from the recreation center visit Tommy at home. They play some video games and Tommy seems to have fun.

The next day, Tommy has to go to his doctor. His mother drives near the recreation center on the way. Tommy begins to cry as they get near it, and mom feels a pit in her stomach and tears up, but doesn't say anything.

Tommy's doctor asks Tommy and his mother about how they and the rest of the family are coping with the accident. Tommy talks about how he still doesn't want to play soccer or go too far from home. Mom tells the doctor privately about Tommy's avoidance and other behaviors, and about her reaction to driving near the recreation center.

**Tommy's** doctor gives mom a handout about typical traumatic stress reactions and tips for coping. The doctor also gives mom a list of local counseling agencies, and asks mom to think about having Tommy and the family meet with a counselor for additional support.

### Intervention Point #5: DISCHARGE PLANNING

**E F** Providers treating Tommy should be aware that:

1. Children and families can become anxious or agitated as a result of the transition from hospital to the home environment, and sometimes experience it as a loss of safety or security. Parents can initially worry about how they and their children will cope on their own, without frequent support.
2. Like many other children, Tommy displays some traumatic stress symptoms — including nightmares and flashbacks. Also, instead of returning to his usual activities, Tommy states that he never wants to play soccer again, a potential sign of avoidance. While avoidance can be common initially after a trauma, it may also signal ongoing traumatic stress responses.

### Intervention Point #6: OUTPATIENT AND GENERAL PEDIATRICS

**D E F** Providers treating Tommy should be aware that:

1. Unexpected hospitalization, pain, and separation from parents are associated with increased risk for posttraumatic stress.
2. Traumatic stress responses can be unrelated to injury severity. Parents who are afraid that their child might die, or children who are afraid that they might die at some point during the trauma event can have more significant traumatic stress responses.
3. Parents and siblings can also be affected. Some parents become hypervigilant or avoidant. Siblings may worry in private about their brother or sister, and may also feel jealous of the special attention their sibling is getting.
4. Tommy has shown some avoidant symptoms — not wanting to get in the car; or go to outpatient appointments; not wanting to play soccer or drive near the recreation center. In addition, Tommy reported nightmares and flashbacks while at the hospital, all of which signal the potential for persistent posttraumatic stress.

See page 12 for recommended assessments and interventions for Tommy and his family.



# How can I help Tommy (and others like him) within the scope of my job?

## PREHOSPITAL PROVIDERS AND FIRST RESPONDERS:

- Minimize additional exposure to traumatic elements at the scene and during transport.
- Encourage parent presence, when possible.
- Provide simple explanations to child about what is happening and what is about to happen, when possible.

## EMERGENCY AND TRAUMA PROVIDERS:

- Acknowledge common emotional reactions to trauma and traumatic stress.
- Ask about fears and worries and provide simple explanations for medical procedures to child and parents to reduce anxiety.
- Encourage parent presence and support parents in comforting.

## INPATIENT HOSPITAL PROVIDERS:

- Connect child and parents to supportive resources in the hospital.
- Help families establish daily routines and behavioral expectations, when possible.
- Provide child with as much age-appropriate involvement as possible in daily care and decision-making.
- Identify family strengths and coping resources, and gauge family distress and other stressors.

## REHABILITATION PROVIDERS:

- Support child's transition to the rehabilitation environment.
- Provide simple explanations for therapies or procedures to reduce the child's fears and worries.
- Encourage and promote a stepped approach to confront emotionally painful thoughts, fears, worries, and avoidant reactions.
- Involve psychosocial staff in a team-based approach to helping the child or family experiencing significant distress.

## DISCHARGE PLANNING:

- Anticipate challenges in returning to the home environment and help families plan accordingly.
- Support child's physical and emotional transition to the home environment.

## OUTPATIENT AND GENERAL PEDIATRICS:

- Monitor child and family's physical and emotional recovery.
- Connect parents to family support resources in the community.
- Make referrals to mental health resources for those with symptoms of traumatic stress and those at increased risk. (See QUICK SCREEN.)

# D-E-F Protocol for Assessing and Treating Children and Families with Traumatic Stress

**D** **DISTRESS** - Use brief assessment and indicated interventions for distress (see pocket card,) including:

- Provide child with as much information about what is happening and choices in decisions as possible.
- Listen carefully for child's understanding and clarify any misconceptions.
- Provide reassurance and realistic hope.

**E** **EMOTIONAL SUPPORT** - Use brief assessment and indicated interventions for emotional support (see pocket card,) including:

- Encourage parents to be with their child as much as possible and to talk with their child about worries and fears.
- Empower parents to comfort and help their child.
- Encourage child involvement in age-appropriate activities when possible.

**F** **FAMILY** - Use brief assessment and indicated interventions for family needs (see pocket card,) including:

- Gauge family distress, coping resources, and other stressors.
- Encourage parents to use own coping resources or resources available at the hospital or in the community.

**D E F** Use **QUICK SCREEN** (see pocket card,) to identify those who have traumatic stress symptoms or who are at greater risk for traumatic stress.

- Involve psychosocial staff in a team-based approach for those at higher risk.
- Make referrals to mental health resources when appropriate.